

Testimony Before  
Kansas Health Policy Authority  
July 11, 2006  
Jack Reardon Center  
Kansas City, Kansas

Executive Director Nielson and members of the Health Policy Authority, my name is Jim Paquette. I want to thank you for this opportunity to discuss an issue that is very important to a large number of citizens here in this community and all across the state – Medicaid. I will address my remarks from the perspective of two roles that I have the distinct honor and privilege to serve - first as the Chief Executive Officer of Providence Medical Center – Providence Health here in Kansas City, Kansas and secondly as a member of the Health Care Access Improvement Panel.

For many folks, Medicaid is the only health care safety net available and hospitals, all too frequently, are the initial entry point to access health care services through that system. It is because of this that the business ties between the state and providers, hospitals in particular, be based upon a strong partnership-like relationship. For that relationship to work for the benefit of all a mutual bond of trust and open communication must exist, otherwise the safety net begins to dissolve. The recent reorganization of Medicaid from SRS to the Division of Health Policy and Finance, under the leadership of Scott Brunner, signaled to providers that the state is willing to strengthen that bond. On a personal level I have worked with Scott on the Access Improvement Panel and have been impressed with his openness and willingness to address issues.

The basis of that relationship begins, of course, with payments; not just the adequacy of those payments but the effectiveness, equity and efficiency of how the payments are processed as well. Hospitals can receive reimbursement from Medicaid in two primary ways – regular payments for inpatient and outpatient services provided and special “disproportionate share” or DSH payments. Both are critical to Providence as one of the largest Medicaid providers in the State.

Our Medicaid adjusted admissions, a combination of inpatient and outpatient volume, has grown to over 1800 in this latest fiscal year, almost 3 times what it was in 2001. The losses we incurred in the care of those patients for the 12 months ended May, 2006 totaled almost \$3.1 million. That is the cost of providing the care minus payments received from Medicaid. Without the Provider Tax, which helped raise the payment rate, the loss would have been \$2.0 million higher. These losses are passed on to employers and individuals in the form of higher insurance premiums. In other words the people who pay for their care pay for the people who cannot or do not pay for their care. This is a hidden tax on all Kansans and why there is a widespread interest in the Medicaid program, not just among the poor.

DSH payments were created by the federal government to help offset the financial losses hospitals incur by treating a high or “disproportional share” of low income or Medicaid patients. Without getting too technical, hospitals in Kansas qualify for DSH payments if they meet one of two thresholds - service provided to low income patients or a statistically determined higher number Medicaid inpatient days than the statewide

average. Logic would suggest that hospitals providing a higher percentage of Medicaid services would receive the majority of the DSH dollars but that is not the case. The program is currently structured such that the 10 hospitals providing 45% of the Medicaid patient days, and Providence is one of these, receive only 6.1% of the DSH payment. We have initiated a dialogue with officials of the Department of Health Policy and Finance to review the current DSH methodology to ensure that DSH dollars are distributed in the most equitable manner possible.

Lastly, I want to direct my comments to my role as a member of the Health Care Access Improvement Panel. In 2004, the legislature unanimously passed the hospital provider assessment bill to improve Medicaid payments to hospitals and physicians. This program, combined with the corresponding federal matching dollars, has increased payments to hospitals and physicians by \$88 million annually.

The panel, which was established in the legislation, was created “for the purposes of administering and selecting the disbursements” of the proceeds of the assessment program. This program is a perfect example of how effective legislation can be when providers, legislators and the administration work together. As a member of the panel, I look forward to working with the Authority to ensure the provider assessment program continues to produce the outstanding results it was designed to do. Thank you again for this opportunity to speak before you today and I would be happy to answer any questions you may have.

